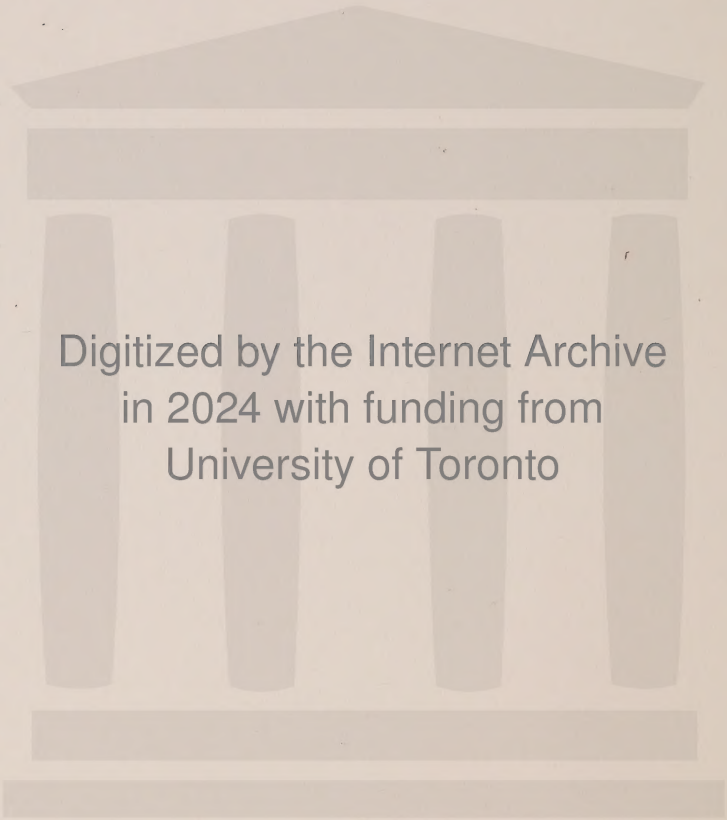
Joint Committee on Physicians' Compensation for Professional Services

REPORT OF THE CHAIRMAN

Paul C. Weiler



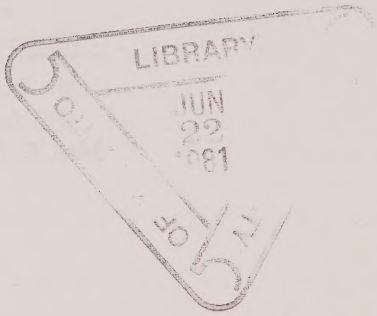
For the
Ontario Medical Association

Dr. William Vail
Dr. Earl Myers
Mr. Don Hersey

For the
Government of Ontario

Mr. Robert Butler
Dr. Boyd Suttie
Mrs. E. M. McLellan

February 20, 1981


LIBRARY
JUN
22
1981

I – Introduction

1. I have prepared this Report in my capacity as Chairman of the Joint Committee on Physicians' Compensation for Professional Services. This Committee has been established under an agreement between the Government of Ontario (the Government) and the Ontario Medical Association (OMA)*. Our task is to recommend the periodic revision of the Schedule of Benefits payable under the Ontario Health Insurance Plan (OHIP). The negotiations about such increases are conducted by three representatives of the Government and three representatives of the OMA. Although the primary role of the Chairman is to coordinate information-gathering and discussions by the parties and to provide them with assistance in reconciling their differences, in the event that either party decides that negotiations have reached an impasse, it may direct the Chairman to act as a fact-finder and to make written recommendations for settlement of the dispute. The fact-finding procedure has been initiated this year, and this is my Report.

2. Before dealing with the substance of the issues which divide the parties, I wish to make a few initial observations about the course which the proceedings have taken this year. The negotiation arrangement contemplates that the Committee will fix a global increase in the OHIP Benefit Schedule in sufficient time for it to be incorporated into the Government's budget and implemented by OHIP on April 1 each year. This year, however, the parties did not agree to the selection of a Chairman until early in December, 1980. We had our first meeting in December, at which time the OMA tabled its opening demands for an increase in the scale of physicians' compensation. A number of meetings throughout January were devoted to developing and documenting the empirical data which were relevant to the issues.[1] On the morning of February 2, the Government representatives put forward a precise monetary proposal in response to the OMA's initial demands. While the parties were then a long distance apart, the parameters for the negotiations had been set. Our assumption was that the parties would now settle down for serious bargaining, with assistance from me as mediator.

3. On the afternoon of February 2, the situation changed dramatically. Premier Davis called a provincial election for March 19. On the morning of February 3, the OMA declared an impasse and triggered the fact-finding procedure. On February 9, the Government presented the OMA with a brief statement containing an improved version of its first offer. On February 12 the OMA delivered to the Government a reduction in its original demands. These last brief exchanges between the parties have taken place in the shadow of my

[1]The committee created a Technical Subcommittee, composed of the senior economists from the Ministry of Health and the OMA. These people largely agreed to the basic economic facts to be used by the Committee, indicating the range of disagreement where it existed. The Committee must wrestle with the major differences of opinion about the appropriate interpretation and evaluation of these economic trends.

*See Appendix, Page 27.

fact-finding exercise, under which I am required to report to the parties within three weeks.

4. I recount this sequence of events not to suggest that there is anything untoward in what has happened. It was only to be expected, for instance, that the OMA would want to insure that it did have the option of making public a fact-finding report at a time when this might well prove an effective lever – i.e., while an election campaign was in full swing. (Neither party can release the Report until at least one week after I have delivered it.) My point is to make clear to the readers of this Report that at the time the impasse was declared, serious bargaining had not yet gotten underway. The gulf between the Government and the OMA proposals is very wide, and the range of options with which one might bridge this divide has not yet been explored by the Committee. Thus, it is impossible for me to make my recommendations according to the typical norms of the neutral – i.e., by identifying a position which is within each side's contract zone and which would appear to be a tolerable compromise to both. That is why I shall spend considerably more time than is usual in such a report on exposing to public view the economic data and trends which are pertinent to the issue of physicians' compensation in Ontario. I have somewhat greater confidence in the reliability of these facts than I do in my own personal reaction to them. In a Report which may be destined to figure in public debate in an election campaign, perhaps this is only as it should be.

II – Price

5. As I observed above, the role of this Committee is to produce the appropriate global revision in the Schedule of *Benefits* paid under the Ontario Health Insurance Plan. This Schedule fixes the amounts which will be paid by OHIP for each of the services which is offered by Ontario doctors to their patients. It must be clearly distinguished from the Schedule of *Fees* issued by the Ontario Medical Association, which sets out what the OMA considers to be the appropriate compensation for its members' services.

6. Of course, the OMA Fee Schedule long antedated the OHIP Benefit Schedule. When OHIP first became effective in 1971, the legislation tied the government-insured benefits to the OMA schedule by reimbursing physicians to the extent of 90% of the relevant price in the OMA schedule. (The 10% discount was an allowance for the fact that doctors were now guaranteed payment for their services from a single government agency.) Changes in the OMA schedule were developed through the process of negotiations of this Joint Committee. However, in 1977 the OMA decided that the level of benefits under OHIP had fallen too far behind the rate of inflation. The Association unilaterally introduced a radical shift upwards in its own Fee Schedule. OHIP responded by severing the umbilical cord which had tied its

benefits to OMA fees and published its own Benefit Schedule. Since that time, the gap between the two price lists has widened even further, such that as of 1980 the OHIP benefits were approximately 69% of the corresponding OMA fees.

7. The OMA has always encouraged its members to deal directly with their patients and to charge the latter in accordance with the OMA schedule. The widening gulf between the two documents has encouraged a growing number of Ontario doctors to take that step; as of this date, about 16% or 17% of the province's doctors have done so. However, a doctor who elects to bill any of his patients at a rate higher than the OHIP Benefit Schedule must collect all his fees directly from his patients (with the exception of a small number of services performed inside hospitals). The patients are entitled to recoup from OHIP, their insuror, the appropriate amount in the latter's Benefit Schedule. However, the opted-out doctor must rely on his own efforts to collect his fees from the patient, and can no longer rely on the guaranteed payment from OHIP. As a result, only about 8% of the physicians' services performed in the province are actually overbilled, at or near the level of the OMA Fee Schedule.[2]

8. This background is significant for precisely this reason: the opening position of the OMA within this Committee was that the OHIP Benefit Schedule should be brought into line with the OMA Fee Schedule. I have already mentioned that OHIP benefits are now only 69% of OMA fees. In addition, the OMA has decided to increase its fees a further 13.9% as of April 1 of this year.[3] This means that an increase of fully 60% in the OHIP tariff would be required to close the gap entirely.

9. It goes without saying that a 60% compensation increase, whether achieved in a single year or over a longer period of time, is a hefty hike indeed. The OMA marshalled a number of arguments in its care for such a major catch-up effort. These are the basic facts upon which it relied:

10. First, there has been a steady erosion of the real value of OHIP benefits since they were first set in 1971. Relative to the Consumer Price Index, OHIP benefits have fallen behind at a rate of 3% a year for the past nine years (for a total of 27%). Relative to the Index of Average Hourly Earnings, the decline has been at a rate of 4.5% a year (for a total of 42%). By contrast,

[2]The OMA Fee Schedule does have official status to some degree. First of all, an opted-out doctor who elects to bill his patients at a rate higher than the OHIP Benefit Schedule must give advance notice to the patient of his proposed fee if, but only if, it will exceed the OMA Fee Schedule. More important, the judgments made by the OMA about how to distribute fee increases between different services and different specialties effectively determine the make-up of the OHIP tariff as well. Thus, as a practical matter, this Committee is concerned only with the global percentage increase.

[3]This figure was arrived at by the OMA Economics Committee by estimating the rate of inflation at 10.9% for the twelve months of 1981, and then compounding this higher to 13.9% in order to take account of the fact that the upcoming OMA Fee Schedule will be effective for fifteen months, until April 1, 1982. The reason for the longer period is that this will bring the OMA schedule in tandem with the Fiscal Year of the Ontario Government, which begins on April 1, and to which the OHIP Benefit Schedule has been adjusted this year.

the OMA schedule has been increased at 110% since 1971 (compared to a CPI increase of 102%), thus providing a moderate increase of only 1% a year in the real value of the fees. Of course, 1971 is not the only relevant year from which to measure movements in the price of physicians' services. There are data about the OMA Fee Schedule going back as far as 1974, although there is some disagreement between the Government and the OMA economists about these data. The latter calculate the total increase in the OMA Fee Schedule from 1964 to 1980 at 180%; the former, 202%. Compared to a cumulative inflation rate of 150% during that period, doctors enjoyed a real increase under their Fee Schedule of somewhere between 15% and 21% during that sixteen-year period. Whatever the precise amount, the OMA asserts that this increase in its Fee Schedule is still far behind the 50% increase in real average hourly earnings and the 80% increase in real per capita income in Ontario during that same time span.[4]

11. The OMA buttressed its case by reference to interprovincial comparisons. From 1971 through 1980, the average increase in provincial benefit schedules across Canada was 82%, ranging down from a high of 108.5% in British Columbia. The OMA calculated that Ontario's total increase was 62.6%, leaving Ontario last out of nine provinces (Quebec having to be excluded from these comparisons because of the peculiar nature of its compensation system for physicians). The Government calculates the Ontario increase at 65.3% during the same period, which would put Ontario seventh out of nine provinces, while still leaving it well below the national average.

12. The difference in these computations turns on the calculation of the 1980 increase in Ontario, a matter which is worth dwelling on in its own right. Erosion in the real value of the OHIP Benefit Schedule was even more evident to the parties at the outset of the Committee's deliberations in late 1979; the Government accepted the premise that some "catch-up" was justified. The parties agreed to a 9% across-the-board increase, plus another $28 million to be used for redress of inequities which had developed in the position of the general practitioners and certain specialties (this amount being the equivalent of another 2.5% in the general scale). However, while this increase of 11.5% in total was implemented entirely as of January 1, 1980, it was to remain in effect until April 1, 1981 (to bring the life of the OHIP schedule into line with the Fiscal Year of the Government). From the OMA's perspective, then, the apparent 11.5% increase has to be discounted in order to take account of the fact that it was for a period of fifteen months. Its annualized value is therefore 9.3% for 1980 alone. Looked at from that point of view, not only did this supposed "catch-up" increase fall short of the yearly inflation rate once

[4]The government argued that a more suitable basis for an earnings comparison is the Average Weekly Earnings of the Business Services Sector (which includes earnings of other professionals as well). Using this comparison, the OHIP Schedule of Benefits has declined 24% since 1971. Going back to 1964, this index shows a real income gain of 33%, as compared to a real increase in the OMA Schedule of Fees of between 15% and 21%.

more, but it left Ontario doctors at or near the bottom of the Canadian rankings again – far behind the Alberta doctors, for example, who won a 15.5% increase in 1980.[5]

13. One standard response to this kind of argument – based on comparisons of rates of change over a period of years – is that it often ignores the size of the base figure at the start of the period. Smaller percentage increases from a much larger base can and do produce considerably higher absolute increases in compensation. But this response is not really available to the Government in connection with the OHIP Fee Schedule. Every year National Health and Welfare Canada produces tables which compare the value of provincial fee schedules in accordance with complex weighted averages (see Table 1). In 1971 the Ontario schedule stood slightly above the national average, at about 105%. By 1980 Ontario was down to 95% of the national average, far below British Columbia at 122% and Alberta at 115%, slightly below Nova Scotia at 100%, and grouped together with Manitoba, Saskatchewan, and Prince Edward Island. Only New Brunswick and Newfoundland lagged behind. (Quebec, again, is excluded from this comparative ranking because of the peculiar character of its system.)

14. A number of other comparisons were made by the OMA to support its case: between the Ontario Fee schedule and those in New York State or in other western countries, and also with the level of hourly rates (and recent rates of increase) for other professionals in Ontario – dentists, lawyers and architects. In all these comparisons, the data are rather spongy, and other variables are difficult to untangle.

15. The central core of the OMA case rests on the factual foundation which I have just depicted. Ever since it was first fixed in 1971, the OHIP Benefit Schedule has been steadily and substantially eroded by inflation. Throughout the Seventies, Ontario has lagged at or near the bottom of Canadian provinces in the improvements which it has made in its OHIP benefits, such that the latter's tariff has sunk from 5% above the national average to 5% below, and fully 30% below British Columbia, the Canadian leader. The OMA believes that its Schedule, which has been kept slightly ahead of inflation during the decade and was approximately at the level of British Columbia's in 1980, constitutes a fair and sensible price for its members' services. It contends that the Government must explicitly accept this target in the Committee's recommendation about the OHIP Benefit Schedule for the next year.

---

[5] In my view, the most accurate way of characterizing the 1980 settlement in its own right (as opposed to comparing it to twelve-month settlements in other provinces) is to accept the fact that Ontario doctors did receive a full 11.5% increase in their Benefit Schedule, one which was in effect all through 1980, and which moved the schedule up to that higher plateau for future negotiations. However, in return the doctors gave the Government a pay pause for an additional three-month period in 1981. The latter fact is something which might be considered germane to the size of the compensation increase in this year.

III – Cost

16. No one would be surprised to learn of the Government's immediate reaction to this proposal. Its spokesmen insist that the cost of such an increase is simply beyond the capacity of the Ontario budget to bear, and more than the Ontario citizen can afford to pay. This is the second dimension to the problem faced by this Committee, one which also produced a great deal of statistical information.

17. During the last several years, the basic fiscal policy of the Ontario Government has been to hold the growth in government expenditures below both the increase in the CPI and the growth in Gross Provincial Product (GPP). In that quest the Government has been successful. From Fiscal Year 1975-76 to FY 1979-80, the real increase in the GPP totaled 11.2%, while the real increase in government expenditures was held to a total of 3.7%. During this period, however, the Ministry of Health budget in general, and government expenditures and doctors' services in particular, grew at a higher rate. Over that four-year span, Ministry of Health budgets enjoyed a real increase of 7.8%, while the real value of OHIP expenditures on doctors' services increased by between 8% and 9%.

18. The Committee received more extensive figures relative to the years just before that time span, and also covering the current Fiscal Year 1980-81 (see Table 2). (The latter involves a projection for the full year based on actual expenditures for the nine months ending December 31, 1980.) These figures are in nominal dollars, and so cannot be compared directly with those I have just sketched above; however, they do serve to depict the relative trends over a somewhat more extended period.

19. In the five years from FY 1975-76 through FY 1980-81, government expenditures in Ontario increased 60% in total and Ministry of Health budgets increased 62%, while OHIP expenditures and doctors' fees increased a total of 78.4%. Thus, the Government spokesmen contend, the Ontario Government has recently been treating doctors more generously than other claimants on the public purse. That trend is quite pronounced in the current Fiscal Year, 1980-81, in which OHIP payments to doctors have increased a full $200 million, a percentage increase of nearly 22%, while the pace of government expenditure as a whole has been kept to 11.4%.

20. Examination of the two previous years (Fiscal Years 1973-74 and 1974-75) changes this picture somewhat. Government budgets in those two halcyon years were up 45%, and the Ministry of Health budget was up 47%, while physicians' services rose only 29.4% (albeit the latter increasing at a healthy pace of 15% a year). In any event, if projected over the entire seven-year period, government expenditures as a whole grew 132%, the

Ministry of Health budget grew 136%, and OHIP payments to doctors were up 130%. The latter figure entails an average compound increase of OHIP payments to Ontario doctors of 12% a year over the last seven years.

21. However generous those figures might look in isolation, the OMA contends that Ontario's efforts still trail the other provinces'. The recent Hall Report collected data from all the provinces for a four-year period, 1975-76 through 1979-80. These figures indicate that Ontario has been dead last of the ten provinces in its rate of increase in total health expenditures (which grew at an annual rate of 8.8% versus the overall Canadian average of 10.3%) as well as in hospital and medical insurance in particular (which grew at an annual rate of 10.2% versus the Canada-wide average of 11.3%). The response of the Government spokesman is that the rate of increase in the Ontario GPP from 1975 through 1980 has also consistently lagged well behind the increase in the Canada-wide GNP, as have increases in Ontario's Average Weekly Earnings. In turn this means that Government revenues in Ontario have grown at a slower pace than have other provinces', far behind British Columbia and Alberta, the only two provinces whose dollar benefit schedules are now well ahead of Ontario and the national average (and which are the OMA target for this year). Still, whatever be the explanation and/or justification, the fact remains that, as Hall indicated, per capita expenditures on hospital and medical insurance were $386 in Ontario in 1979-80, as compared with $408 in Canada as a whole.

22. Whatever be the nature and significance of these interprovincial comparisons, they pale by comparison with the major issue lurking beneath the surface of these aggregate figures of OHIP expenditures and physicians' services. How can it be the case that the price increase in the OHIP Fee Schedule has lagged behind the rate of inflation in the last seven years, while the total Government bill for doctors' fees has consistently increased in real terms? The answer is quite simple. The total OHIP bill is a function not only of price, but of volume as well. While the OHIP Benefit Schedule has been increasing at a relatively modest pace in the past seven years, the utilization of doctors' services in Ontario has been steadily growing during that same period. It is the combination of the two which has generated the increasing share of OHIP's expenditures in the Government's budgetary resources.

23. These are the relevant figures (from Table 3): from Fiscal Year 1973-74 through FY 1980-81, OHIP payments to doctors increased by more than 128%, for a total of more than $600 million. During this seven-year period, the cumulative price revision in the Benefit Schedule produced a 63% increase in OHIP expenditures, accounting for slightly over $300 million. During that same period the rate of utilization of doctors' services by Ontario residents increased by 38%, and this accounted for approximately the same dollar increase in the total Government bill for doctors' services; again,

slightly over $300 million. However, less than one-third of this volume increase is accounted for by this physician-population factor. The largest share by far comes from an increase in the services provided by individual physicians to their patients. This ratio has been increasing at a rate of more than 2% a year for the past seven years, and has produced a $210 million hike in OHIP expenditures over that period. By itself, this growing utilization by individual Ontarians of their own doctor has generated more than one-third the total increase in OHIP payments for physicians' services.

24. In no year has the impact of this last factor been more starkly displayed than in the current one. As I described earlier, the increase in the OHIP Benefit Schedule amounted to 11.5% as of January 1, 1980. But the overall utilization factor increased by more than 6% – made up of a 3% increase in the supply of physicians (as contrasted with an increase in the Ontario population of only 0.9%) and a further 3.1% increase in the amount of services provided by the average Ontario doctor to his patients. The result is that in 1980 the total OHIP payments to doctors were fully 18% (and $200 million) higher than they had been in 1979. These are the budgetary problems which confronted the Government as it received the OMA's proposal for a major hike in the price level for 1981.

IV – Income

25. Increases in this physician-utilization ratio are pertinent not just because of their impact on the Government's aggregate OHIP budget; they directly influence the *income* of physicians as well. An individual doctor's annual income is the product of the price charged for his individual services times the volume of services which he provides to his patients. Even if the price schedule is enjoying only modest increases, doctors' earnings can move sharply ahead if the per capita utilization factor pushes volumes upwards. The OMA argued that such changes in utilization should *not* be ultimately decisive in determining OHIP price levels. The Government representatives on the Committee disagreed. I shall consider their respective arguments in the next section of this Report. In this section I shall try to set out the relevant facts underlying that debate.

26. First, the Committee does have accurate data about the current situation of Ontario doctors and movements in these incomes in the past three years (see Table 4).[6] In 1980, the average net income in Ontario of full-time general practitioners was approximately $58,000; of specialists, $87,000; and of all physicians, $71,500. The average 1980 income for all physicians was approximately $10,000 higher than in 1979. This 16.5% jump in net earnings testifies vividly to the manner in which higher utilization ratios can multiply an increase in the price schedule, which, recall, was fixed at 11.5% for 1980. The distribution of the global price hike which was fashioned by this

Committee for 1980 did have an impact. The average income of Ontario specialists rose $10,500 in 1980, for an average of 14%, while general practitioners, who were given an extra adjustment, enjoyed an average increase of $9,700 last year, or fully 20% higher than their 1979 base. Much the same pattern can be seen in the previous two years. The Benefit Schedule was increased by 6.6% in 1979, but physicians' earnings rose by over 11.5%, or $6,500 (made up of nearly 13.5% and $1,600 for G.P.'s, and 10.75% and $7,500 for specialists). In 1978 the Benefit Schedule was increased by 6.25%, while all physicians' incomes rose by nearly 8%, or $4,000 (broken down into over 8% and $3,000 for G.P.'s; 7.75% and $5,000 for specialists).

27. In trying to appraise these figures in the context of relative increases in the incomes of doctors in other provinces and of other professionals in Ontario, we face a significant hurdle. Unlike movements in physicians' prices, available data sources permit of such income comparisons only up to 1978. They do not allow us to take account of what has been happening in Ontario and other provinces in the last two years, years which are particularly important because they immediately followed the dismantling of the Anti-Inflation Program. With that caveat, I will provide the interprovincial comparisons of doctors' incomes from Health and Welfare Canada tables (see Table 5), which rank all provinces on the average *professional* earnings of physicians with *net* professional income of $20,000 or more (another surrogate for the full-time medical practitioner).

28. In 1973, two years after the institution of OHIP, Ontario doctors ranked second in average annual incomes, behind only Quebec. In the next three years, they dropped progressively to a low position of number six in 1976. Since that year, Ontario doctors moved back to number five of all provinces in 1977, and to number three in 1978 (behind Nova Scotia and Quebec).

29. These rankings are distorted somewhat by the varying distribution of specialists and general practitioners in the different provinces. Since a specialist earns more than a general practitioner, a province with a higher concentration of specialists will appear to have more generous income levels

---

[6] Figures in the text are made up of payments from Ontario Government sources: dominantly from OHIP, but also from the Workers' Compensation Board, whose rates for treatment of occupational injuries are set at 11% above the OHIP schedule (in order to give treating doctors a premium for their reporting duties under Workers' Compensation). All income from non-government sources is excluded; not just non-professional income from investments, but also professional income derived from over-billing by opted-out doctors, insurance examinations, legal reports, treatment of non-residents and armed forces recipients, and so on. Secondly, these are average incomes of those doctors whose gross payments are above the thirtieth percentile of doctors in Ontario. The aim of this exclusion is to permit us to concentrate on the situation of the *full-time* practitioner, which necessitates the exclusion of both doctors who are primarily teachers or administrators but who have a small professional practice on the side, and doctors who are semi-retired. Finally, the figures describe average, net pre-tax income (after deducting office expenses) computed in accordance with a Health and Welfare Canada formula. In my view, these figures give us the closest approximation of the recent and current income status of those doctors whose Fee Schedule is the primary focus of this Committee: the full-time practitioners who rely on OHIP payments for their livelihood.

for all physicians than is really the case. If we isolate the general practitioner in Ontario, his position in the interprovincial rankings looks less favourable. In 1973 the average earnings of Ontario G.P.'s ranked sixth among the ten provinces. It dropped to number nine in 1974, and was still number nine in 1977. Only in 1978 did the Ontario ranking move up, and then just to fifth. Of course, as I mentioned earlier, it was in 1979 and 1980 that Ontario G.P.'s enjoyed major income gains of more than 10% and 20% respectively (for a total absolute increase in the two years of $14,000 in their net pre-tax income). Because the Health and Welfare Canada tables are always two years behind, we cannot know whether these increases pushed Ontario G.P.'s further up in the interprovincial rankings.

30. A further telling fact is contained in these interprovincial income tables. Throughout the Seventies, the average doctor's earnings in Newfoundland have been at or slightly above those in British Columbia (depending on the year and the particular table used). But, as I observed earlier, the British Columbia Benefit Schedule is, by a considerable margin, the highest in the country, more than 20% above the national average. Newfoundland is at the bottom of this scale, and was at 15% below the national average until a big 15% fee increase in 1981 brought its schedule up to the 88% mark. British Columbia has the largest number of doctors per capita in the nation, and Newfoundland the fewest. It is the much higher volume of services performed by each Newfoundland doctor, by comparison with his British Columbia counterpart (i.e., the higher physician-utilization ratio), which lifts average physicians' incomes in Newfoundland up to and even past those of British Columbia.

31. The other relevant comparison is with movements in professional income (and also with industrial wages). The OMA attempted to draw direct comparisons between doctors' fees and supposed hourly rates for lawyers, architects, dentists, and even plumbers. Frankly, I do not find this type of comparison persuasive. The hourly rate for doctors is an artificial construct from the Benefit Schedule. More important, the considerably higher hourly rates of the other professionals disguised sharp (and unfavourable) differences in average overhead costs, years spent as a salaried associate in a firm, the age at which peak earnings potential is reached, and the volume of available work which could be billed at these hourly rates. If comparisons are to be made between doctors and other professionals, they must be between the net annual incomes of full-time practitioners in the several disciplines.

32. In Ontario, as elsewhere in Canada, doctors have consistently led the other professions in income, although in the especially "drier" years of the mid-Seventies, doctors dipped below the lawyers. The doctors' lead was clearly restored by 1978, the last year of available data. One apt indication of

how well Ontario doctors are faring relative to their peers is to compare the ratio of physician to other professional earnings in Ontario to a similar Canada-wide ratio. In 1978, Ontario doctors enjoyed a 17.7% differential vis-a-vis lawyers, dentists, architects and accountants, whereas Canadian doctors as a whole were 25.5% ahead. Even more suggestive from the OMA's perspective, Ontario G.P.'s enjoyed only a 1.1% income differential, while in Canada as a whole the gap was 11.1%. Again, we have no later data to tell us whether the relative position of Ontario G.P.'s and physicians as a whole has been improved by the sharp absolute increases in their professional incomes in 1979 and 1980.

33. A final comparison may revise one's impressions once more. In 1978, according to Revenue Canada statistics, Ontario doctors' net income was 4.1 times the Average Industrial Earnings, which is higher than the 3.8 ratio in Canada as a whole. In that same year, Ontario doctors' net incomes were 6.4 times the average per capita earnings in the province, versus a Canada-wide ratio of 5.4. As of that year, in any event, while the annual incomes of Ontario doctors were not as high relative to other professionals as were Canadian doctors' as a whole, Ontario doctors (and other professionals in this province) enjoyed a higher income margin over Ontario's industrial workers and other citizens than obtained across Canada.

V – The Positions of the Parties

34. In the previous Section I have tried to organize and lay out the factual data in as neutral a fashion as possible. Here I shall summarize the key empirical trends and relate them to the positions taken by each side within the Committee.

35. Unquestionably the real value of the OHIP Benefit Schedule declined persistently in the nine years since OHIP was instituted in 1971 – up to 27% as measured by price inflation, and 42% relative to wage inflation. In interprovincial terms, the Ontario tariff has declined from 5% above the national average to 5% below it, and to fully 30% behind British Columbia, the national leader. The OMA initially proposed that the OHIP Benefit Schedule be raised to the level of the doctors' own Fee Schedule, which has been adjusted to stay above the CPI by 8% since 1971 and by 15% (20% according to the Government) since 1974; it is now approximately at the level of British Columbia's tariff. When account is taken of the 13.9% increase planned for the OMA schedule as of April 1, 1981, adoption of this proposal would require a 63% increase in the OHIP Benefit Schedule this year.

36. The Government viewed the recent past from an entirely different perspective. In the last five years, health care expenditures in general, and OHIP payments to doctors in particular, have been steadily increasing in real

terms, at a pace more than double the overall Government budget. In the current budget year, OHIP expenditures on physicians rose 22% – or $200 million, to just over $1.1 billion – as compared with a less than 9% rise in Ontario Government expenditures. To meet the OMA's original proposal would require another $700 million (assuming a 5% increase in the utilization rate). Government revenues for the next year are not expected to grow faster than the CPI, about 10-11%. Other claimants on the public purse – universities, local school boards, public health programs, and so on – have been granted budget hikes in that 10% range for the next Fiscal Year. If doctors were to receive the dramatic jump sought by the OMA, these other program recipients would have to take less. The Government was not initially prepared to acknowledge that Ontario physicians are entitled to a catch-up increase this year. Thus, its first proposal was to add another $135 million in the current budgetary envelope of $1.1 billion for doctors' services, amounting to just over 12%. Given the historical utilization increase of 5%, this would leave a price increase of 7.4% in the OHIP Benefit Schedule.

37. As of February 2, when I was directed to begin writing my fact-finder's report, this was the gap between the parties: the OMA was seeking a 63% increase in the OHIP tariff, the Government offering only 7.4%. Coloring the dispute between them was a third dimension – income – whose status was clear but whose significance was hotly contested. Total incomes of doctors in Ontario have been rising at a pace much faster than the price for individual physicians' services, especially in the past two years, following the demise of the Anti-Inflation Program (with its $2,400 ceiling on annual income increases). In 1979, the *professional* income of *full-time* physicians derived from Government revenues rose by 11% (amounting to $6,500) and in 1980 by 16.5% (or $10,000), to bring the current level to over $71,000. As noted earlier, the latter figure excludes all forms of professional income from sources other than OHIP and the WCB. In the Government's view, a conservative estimate of an additional 5% from these outside sources would bring the average net income of full-time physicians in the province to about $75,000 a year (although, clearly, the distribution of this extra money is much more uneven than are receipts from the Government insurance programs). This fact added greatly to the Government's doubts about sharply raising the OHIP price tariff this year at the expense of other programs which benefit lower-income citizens of the province.

38. However, the Government has made one improvement in its opening position. It now offers the OMA a 10.25% increase in the OHIP Benefit Schedule, plus an additional $15 million to be expended on those services performed by general practitioners and certain other specialties which still lag behind. This package is the equivalent of an 11.75% overall price increase. Taken by itself, this higher fee schedule would raise average incomes of

full-time physicians by $8,400 this year. However, if one takes into account the historical 2% rise in utilization per individual physician, Ontario doctors could anticipate another increase of $10,000 in their average earnings. Assuming the overall increase in utilization will be 5%, the OHIP budget for doctors would have to absorb an additional cost of about $175 million.

39. In response to this move, the OMA also modified its first demands. It no longer asks for 100% of the OMA Fee Schedule. While still of the view that the latter represents the fair value of its members' services, the OMA is prepared to accept from OHIP just 80% of this scale. To achieve that target this year would require a 30% increase in the OHIP tariff, versus the 11.75% proposed by the Government. In and of itself, this would raise net incomes of full-time practitioners by $21,500. Together with the 2% increase in per-physician utilization, it would actually produce an income increase for full-time doctors of nearly $22,000 this year (versus the $10,000 increase entailed by the Government offer). By itself, a 30% price hike would cost OHIP another $340 million. Taken together with a 5% increase in the aggregate utilization factor, the aggregate cost to the Provincial Treasury would be an additional $385 million this year (versus the $175 million the Government has now placed on the table).

VI – Principles for Appraisal

40. As these last figures indicate, while the gap between the parties has narrowed somewhat, they remain far apart. The primary purpose of this Report is to set out for public scrutiny the basic economic data and financial implications so that the interested reader can make up his own mind about the respective positions of the parties. However, the terms of my appointment as Chairman of the Committee require that I offer a personal recommendation about the appropriate revision of the Benefit Schedule for next year. Underlying any such conclusion are a number of key principles on which the OMA and the Government took quite different positions inside the Committee, thus explaining why the gulf between them is so wide. Before I commit myself to a specific number, I shall take the reader through the important issues with which I have had to wrestle in the course of the Committee's deliberations, and about which I have now reached at least a tentative judgment.

41. Let me deal first with the implications of the actual size of doctors' incomes. The facts are, as I have made clear in this Report, that in 1980 full-time physicians in Ontario earned an average of $71,500 in net, pre-tax income from OHIP and the WCB alone; that the average professional income of full-time physicians from all sources was closer to $75,000; and that these totals had risen fully $10,000 from 1979. I am sure that the immediate reaction to these figures by some readers of this Report is that Ontario doctors

are earning quite enough money already and do not deserve any significant increase this year (let alone a restoration of the historical value of their fee schedule). This is *not* a sentiment which I share. I have always believed that consideration of doctors' incomes on a purely annual basis gives quite a distorted picture of their relative economic situation. To earn this kind of money, doctors work considerably longer than the average 35- to 40-hour work week (and do so with no overtime premiums). Doctors must provide for their own retirement income and fund their own welfare and income package, fringe benefits which usually comprise an additional 10% in the compensation package of the typical employee. Furthermore, the apparent high annual earnings must be discounted by the high marginal tax rates faced by professionals. Most important, doctors invest up to twelve years in post-secondary education and training in order to get into a position in which they can make this net, per-hour, after-tax return in their peak earning years. All in all, doctors' incomes in Ontario are not out of line with the economic valuation placed on physicians in other provinces of Canada or other countries of the world. This province must stay competitive with these other systems in order to recruit and keep its own high-calibre medical talent, and to maintain the morale of its resident medical practitioners, on whose efforts depend the health and well-being of Ontario citizens.

42. Next, I do not find terribly persuasive the Government's data regarding the aggregate cost of the system. Recent increases in the overall volume of medical services stem, to some extent, from a growing patient population in Ontario and from even greater growth in the number of doctors serving this population. The Government has some leverage with which to contain the physician population of the province – particularly through its budgetary control over the number of places in Ontario medical schools – although it cannot unilaterally restrict the rate of in-migration from other provinces or countries. Be that as it may, I empathize with the OMA's view that the individual doctor who grew up in Ontario, went to medical school here, and worked to build up a practice in the province, should not have to absorb a cut in the real price paid for his services because the budgetary envelope which the Government wishes to allocate to OHIP is strained by the growing number of people living in the province and the even greater number of doctors attending to their needs.[7]

43. One cannot so easily dismiss the relevance of the per-physician utilization factor and its impact on the income of doctors. This is the issue which is at the core of the dispute between the Government and the OMA.

---

[7] I do not mean to imply that these economic facts of life can never be relevant. In the short run, the Government's ability to pay the fair relative price for physicians' services may be restricted by the fact that it must accommodate in the same budget an explosion in demands upon the health care system. But, as the OMA contended, these overall budgetary constraints do not preclude the Government's recognizing the actual value of a doctor's work (which, the OMA suggests, is embodied in its own Fee Schedule) and agreeing to pursue this goal in the longer run.

What is to be the basic criterion for translating society's measurement of the economic value of a doctor's work: the fees paid for each individual service, or the flow of net income received over a year (or some other relevant period)?

44. The OMA had no doubt about the proper measure. It should be the price paid for specific medical procedures. From its point of view, doctors are independent, self-employed, quasi-entrepreneurs. They are the equivalents of other professionals such as lawyers, dentists, architects, and accountants. The OMA wants no suggestion that its members should be started down the path towards employment as staff doctors working for the Government, guaranteed an annual salary from OHIP. It insists on a fair evaluation of the fee for each service provided by the doctor to his own individual patient. The OMA feels that the patient should sort out with OHIP (the patient's insuror) the larger cost implications of public health insurance in Ontario.

45. In one sense this Ontario Government tacitly accepts this basic conception of the medical practitioner. It does not want to conscript Ontario doctors into a public bureaucracy. Thus, both sides on the Committee worked from the premise that we are to fix a percentage increase in the *price* tariff for specific medical services. We should not try to establish a target income for different types of doctors (perhaps even making allowance for the variety of fringe benefits normally paid employees).

46. Unfortunately, this premise does not tell us how actually to determine the proper value of a doctor's services, and then how to maintain this valuation through changing economic conditions. It is more than a little ironic that the OMA has tried to demonstrate the legitimacy of its own Fee Schedule by drawing comparisons with movements in other people's incomes (whether general wages and salaries or professional incomes), or with the Consumer Price Index (whose fundamental relevance lies in the fact that it is now commonly used as a justification for a change in people's incomes). In my view, the OMA cannot have it both ways: it cannot argue that changes in the incomes of physicians are irrelevant to the question of how much to adjust the price of doctors' services, yet at the same time appeal to trends in other people's incomes (whether direct or indirect) to justify the increase it wants in its own Schedule of Fees.

47. I suppose this point is clear enough as regards changes in the Index of Average Hourly Earnings, for example. What about the *Consumer* Price Index? It is obvious why this index is so often appealed to in collective bargaining for wage gains or used as an index for automatic adjustments in pension benefits, for example. The primary use of personal income is to purchase consumer goods and services. If the price of these goods is rising generally, then so also must personal income rise in order to preserve the real economic position of the income recipient. Insofar as doctors are concerned,

they are entitled to make the same equitable claim if the real value of their incomes is being eroded by inflation in the goods and services used by them and their families.[8]

48. But that claim is much less compelling once we focus on the *price* for physicians' services, rather than on the net *income* of doctors themselves. A businessman does not fix the price of the services of his firm by direct reference to the CPI.[9] Instead, he marks up his price as his costs of production rise, in order to maintain the appropriate return on his investment (abstracting for the moment from short-term changes in demand). In the case of doctors, the most obvious cost of production consists of overhead – staff, equipment, office rent, and so on – which typically absorbs about one-third of the gross revenue from practice. Only on the rather artificial assumption that these costs per unit of service move directly in tandem with the CPI are we justified in automatically adjusting doctors' fees in accordance with this index in order to cover increases in such costs.

49. But the most significant item in a medical practice which has to be covered in the fee is the doctor's own time and labour. Herein lies the most puzzling issue in this entire dispute. How are we to interpret the continuing increase in volume experienced by individual practitioners ever since the institution of OHIP in 1971 (which has produced average income gains for doctors far in excess of increases in the price schedule)? Has the ''cost'' of satisfying this demand – in the sense of the personal effort expended by the doctor – gone up comparably, such that the increase in annual incomes should be ignored in changing the price of the doctors' individual services?

50. From one perspective it is easy to reach the latter conclusion. If the higher volume of services provided by each doctor to his patients simply means that this doctor must work harder – either longer hours each day, or at a faster pace during the day – it is hard to see why this greater effort by the individual doctor in meeting the additional demand generated under Medicare is a decent reason for reducing the price paid for each unit of his services. To give a simple analogy, if a person has worked 40 hours a week to earn $20,000 in one year, but increased demand for his services requires that he work 50 hours a week and thus earn $25,000 in the next year, one would hardly consider the latter $5,000 ''gain'' in income to be a reason to deny him an increase in his hourly wage to keep it even with inflation. Thus, the position of

[8] I do not mean to imply from the above that I endorse total reliance on the CPI as the criterion for income gains. To the extent that aggregate price inflation has been generated by unfavourable movements in external markets, all participants in the domestic economy should be absorbing cuts in their real income. Contrariwise, to the extent that productivity gains produce a higher per capita GNP, all Canadians are presumptively entitled to real income gains. Thus, movements in relative income levels, rather than in the CPI, should be the primary determinant of income changes for particular groups.

[9] The CPI is a measure of average price increases in a fixed basket of goods and services. The price of some ingredients in this basket will go up faster than the average (e.g., in recent years, energy), but the price of much the same number will go up less than the average, some perhaps even falling (microconductors, for example). Otherwise the CPI figure in question would not be an average.

the OMA is that the recent income increases of Ontario physicians are really illusory: they simply reflect the fact that doctors have had to work longer and harder in an unattractive, revolving-door style of practice in order to meet the increased demand generated by public health insurance. This kind of income "gain" is no reason to force the doctors to accept a real cut in the price of each unit of labour and personal effort which they provide to individual patients.

51. As the Government representatives pointed out, however, there is another, equally plausible explanation for the way in which higher volume has been translated into higher net incomes for Ontario doctors. The introduction of Medicare removed the financial hurdle to patient contact with doctors and generated a growing per capita utilization of individual doctors by individual patients. In turn, this has facilitated major efficiencies in medical practice in the province: elimination of the need to bill individual patients and to try to collect bad debts; a lower ratio of staff and overhead to gross revenues; more efficient use of the doctor's time through contact with patients who are waiting for him; technological changes reducing the time needed to perform certain services; and so on. To the extent that any or all of these possibilities do obtain, they will register in the overall OHIP figures as higher fee-for-service payments to physicians, and thus higher average incomes for individual practitioners. But unlike the OMA hypothesis above, these are pure productivity gains. They do not entail a higher cost to the doctor in terms of his own workload and effort. Thus, if the doctor is really to be viewed as an entrepreneur, the natural response in the marketplace would be to lower the real price per unit of service, while still permitting a growing rate of return to his practice.

52. The problem confronting the Committee is that each of these theories is inherently plausible. They point in opposite directions as regards the appropriate revision in the price tariff, but we do not have the data which will tell us whether and to what extent each is borne out in real life.[10] The overall OHIP figures about rising volume are consistent with either view.

---

[10] I should mention a third hypothesis, one which is found in a controversial theory in present-day health economics – the notion of physician-induced demand. This theory begins with the evident fact that once a patient contacts his doctor about an illness, the doctor – a professional expert – will heavily influence future judgments about the type and extent of treatment. It is also the case that aggregate utilization is primarily composed of treatment which flows out of this initial patient contact. What is controversial in the theory is the claim that physicians can and do manipulate their powers of discretionary advice and judgment about treatment in order to generate levels of service which will maintain their target incomes, even in the face of fee schedules which are being eroded by inflation. Understandably, doctors do not react favorably to this thesis. Some of the OMA antipathy to any reference by this Committee to utilization and income (rather than pure price) stems from its fear that the hypothesis of "physician-induced demand" would underlie such a focus. The OMA economists provided the Committee with materials which indicate that the theory in question remains hotly contested in scholarly circles. Thus, as far as I am concerned, this Committee should be agnostic about it, and not rest its judgments on this premise. But, as I have explained in the text, the simple fact of increasing volume and utilization per physician (however caused) can generate major efficiencies in the use of the doctor's time and other productivity gains which would dictate a reduction in the real price per unit under the classic economic model, while still leaving a decent and growing return to the doctor in his overall practice.

53. My personal intuitive sense is that both tendencies have been operative in medical practice in the province. In the last decade Ontario doctors have had to work somewhat harder to achieve their current income levels under an eroding scale of prices, but they have also profited from the economies of scale and time which flow from higher service volumes under Medicare. I do not have – nor do I think anyone now has – accurate estimates of how much of these recent income increases should be attributed to each of these trends. Until these estimates are available, we cannot make a final judgment about the extent to which the OHIP Benefit Schedule should be adjusted.

54. Still, we need not have that final judgment in order to decide what to do this year. I do assume that Ontario doctors are entitled to some catch-up, but I am also satisfied that the fiscal realities of the Ontario economy and the Ontario budget preclude this taking place all at once. The recommendation I shall make for this year (in the next section of this Report) will involve an initial step in the restoration of the valuation of doctors' services. In the longer run, though, this Committee must initiate and oversee extensive study by both the Government and the OMA of the larger issue which I have just sketched in this section, in order to decide how far this process should go.

VII – Recommendation for Settlement

55. As I have just noted, I am satisfied that Ontario doctors are entitled to some catch-up in their Benefit Schedule this year. In deciding on the actual amount, it is worthwhile reviewing the history of precisely how Ontario doctors did fall behind in the past decade. The OMA Schedule of Fees long pre-dated OHIP. The practice of the OMA was to revise its schedule every two years, and it was increased by 4.5% on May 1, 1971. OHIP was put into effect that same year and paid 90% of the OMA Fee Schedule. However, for a variety of reasons no increase was made in that tariff in 1973, as would normally have been the case. Instead, the parties were developing the initial arrangements for this Committee, which was not in place until the end of 1973.

56. The first Report of the Committee was issued in early 1974, proposing increases of 7.75% on May 1, 1974, and 4% on May 1, 1975, with nothing retroactive for 1973. Of course, the years 1973-1975 was the very era in which Canada first experienced the severe double-digit inflation of the Seventies. Thus, the OMA sought a reopener in their agreement in late 1974 (a not unusual step in collective bargaining at the time). The Government refused, saying that any adjustments would have to await the scrutiny of the Committee at the end of 1975.

57. Unfortunately for the doctors, by the time that date rolled around the

Federal Government had imposed the Anti-Inflation Program, with its tight ceiling of $2,400 for annual income increases. For higher-income professionals such as doctors, this numerical cap foreclosed adjustments for any distortion in the structure of earnings which had taken place in the pre-AIP period. The increases in the Benefit Schedule for the next three years were designed to do no more than generate an average annual net increase for Ontario doctors under the Plan of $2,400: 8.1% on May 1, 1976; 6.5% on May 1, 1977; and 6.25% on May 1, 1978 (lasting until December 31, 1978, when the Anti-Inflation Program expired).

58. One result of this sequence of events was that at the end of 1977 the OMA decided unilaterally to hike its own Schedule of Fees by fully 30% in order to restore what it believed was the proper historical valuation of doctors' services. OHIP responded by severing the umbilical cord with the OMA Fee Schedule and issuing its own Schedule of Benefits. Since that time, the OHIP increases flowing from this Committee – 6.6% on January 1, 1979, and 11.5% on January 1, 1980 – have been tracked closely by the OMA in its own tariff, such that the OHIP level now remains at 69.5% of the OMA Fee Schedule.

59. There are several lessons which might be drawn from this tale, some not immediately germane to this Committee's work (in particular, how *not* to design an income policy in an anti-inflation program). For our purposes, the Seventies can be divided into three periods: (i) 1971-1975, post-OHIP and pre-AIP; (ii) 1976-1978, the AIP itself; and (iii) 1979-1980, post-AIP. The last period did not in and of itself aggravate our problem. Doctors have done well enough in 1979 and 1980, relative to both price inflation and, more important, to wage movements in Ontario. The difficulties we face are a product of the previous two periods, or rather, of the interaction of the two.

60. One major difficulty inherent in the Anti-Inflation Program was the absolute $2,400 lid on annual income increases, a feature whose effect was to compress sharply the earnings of higher-paid professionals, and to drop them behind both price inflation and relative wage gains. However dubious I am about the virtues of this type of redistributive measure as part of an anti-inflation policy, I am hesitant to suggest that this Committee now propose to undo the effects of a provision which was, after all, the law of the land – passed by Parliament, not the Legislature of Ontario. As well, I might observe that Ontario doctors did manage to escape the full force of the income ceiling. Since the percentage increase in the Schedule of Benefits was calculated to produce an average net income gain of $2,400 for *all* Ontario doctors, it actually produced income gains on the order of $4,000 for the full-time practitioners. (I hasten to add that this was fully in accord with the AIB regulations, which clearly imposed its restraints on the compensation "unit" as a whole, not specific segments within it.)

61. The real problem with the Anti-Inflation Program lies in another quarter. Controls were suddenly imposed as of a specific date – October 14, 1975 – on a volatile economic climate in Canada. They deprived this Committee of the leeway to make the type of adjustment in physicians' fees which was needed to undo the impact of unanticipated double-digit inflation in 1973-75 on a leisurely process for revising doctors' fees, one which had been designed for an earlier, more stable era.

62. The Government's offer this year tacitly concedes the fact that Ontario doctors still suffer from some residual inequity flowing from this period. Its representatives on the Committee have already put on the table a package increase of 11.75% over the existing price level. This figure is significantly higher than the 10% level of improvements in other Government programs, such as universities, local school boards, and even hospitals. It also tops the current range of Government settlements with its own employees, such as those in the professional and scientific categories (less than 10%). I take this to be Government recognition of the fact that the situation of Ontario doctors under OHIP has declined sufficiently in the Seventies that remedial steps must be taken this year, even in a general climate of economic restraint.

63. On the other hand, the final OMA position also acknowledges that its own schedule – now unilaterally set and altered by its members – cannot be the sole measure of what OHIP can pay. Historically, Ontario doctors were willing to accept from OHIP 90% of their fee schedule in recognition of the fact that comprehensive public insurance eliminates their bad debts and collection costs in the short run, and generates economies of scale in the longer run. Even this 90% differential, superimposed on a pre-Medicare price tariff, is not carved in stone. It generated unprecedented relative income gains at the start of this decade for both Ontario and other Canadian doctors. The OMA is now prepared to accept 80% of the 1981 OMA schedule as the Government's contribution. Even this level would require a very hefty jump of 30% in the OHIP Benefit Schedule, on which, I am sure, Ontario doctors appreciate cannot be accommodated in the Government's budget (let alone in its wage-determination program) all in one year. In light of these fiscal realities, the OMA has indicated that it is ready to negotiate the time frame within which this relative improvement in the OHIP schedule is to be achieved.

64. Perhaps the clue to solving this puzzle can be found in another look at the 1980 price revision. Originally the promised catch-up for Ontario doctors was intended to start that year. In and of itself, an 11.75% increase could be considered a generous beginning. However, when one realizes that this increase covered a 15-month period rather than a calendar year, its annualized value does not seem actually to have served that purpose. In my view, account

can and should be taken in this year's settlement of the fact that the Government effectively enjoyed a pay pause from the doctors for the first three months of 1981. On that premise, I recommend the equivalent of a 14.75% increase in the overall OHIP Benefit Schedule, effective April 1, 1981. Moreover, I endorse the Government's proposal that approximately 1.5% of this global revision be used for upgrading the Price Schedule of general practitioners, anaesthetists, Northern physicians, and other specific groups which deserve special adjustments.

65. Let me make these final observations about this recommendation. If it is accepted, it will represent a first tangible step in closing the gap between the OHIP and OMA schedules. I am conscious of the dollar magnitudes which this step entails. In and of itself this percentage increase in the price schedule would generate an average increase in net income of $10,500 for full-time practitioners in Ontario. But if the historical 2% rate of increase in per-physician utilization continues unabated, the actual income increase would be closer to $12,000 this year. Further, if Ontario experiences another 5% rise in utilization of the entire system, the OHIP bill for physicians' services could jump $220 million. In my view, these figures are at the outer limits of the fiscal capacities of the Ontario Government, and Ontario doctors could not realistically expect any more this year.

66. While this recommendation rests on my view that the OHIP Fee Schedule has fallen behind in the past decade, it does not embody an endorsement of any particular ratio between the OHIP and OMA schedules. As I have developed above, an intelligent judgment in that matter requires analysis of the extent to which the rising *incomes* of Ontario physicians (over and above the rate of increase in their *price* level) are a function either of a more onerous work pace demanded of doctors or of productivity gains under public health care increases. Ultimately this is an empirical issue – admittedly a difficult one – and will have to be tackled by the research staffs of the parties under the auspices of this Committee. Finally – and I emphasize this point strongly – during this same period the Ontario Government is going to have to exercise its responsibility to deal with the utilization factor itself; i.e., to institute the measures needed to contain the growing volume of medical services demanded by Ontario citizens in order to make it economically feasible to pay an appropriate price for these services.

Paul C. Weiler
Chairman

TABLE 1

HEALTH AND WELFARE CANADA
AVERAGE BENEFITS – NATIONAL INDEX, ALL SERVICES
ALL PHYSICIANS, EXCLUDING RADIOLOGY AND LABORATORY SERVICES
RANKING BY PROVINCE

	1	2	3	4	5	6	7	8	9	10
1971	Que. 109.95	Alta. 106.76	Ont. 105.72	Man. 104.78	B.C. 101.52	P.E.I. 97.29	N.B. 96.68	Sask. 94.90	N.S. 94.05	Nfld. 88.35
1972	B.C. 109.27	Alta. 108.35	Ont. 103.42	Man. 102.93	Que. 101.17	P.E.I. 98.44	N.S. 98.44	Sask. 95.05	N.B. 94.80	Nfld. 88.14
1973	B.C. 114.43	Alta. 112.57	Ont. 101.66	Man. 100.68	N.S. 99.76	Que. 97.75	P.E.I. 96.72	Sask. 92.38	N.B. 92.30	Nfld. 91.76
1974	B.C. 117.81	Alta. 106.62	N.S. 104.10	Ont. 103.80	P.E.I. 103.39	Man. 102.51	Que. 94.73	N.B. 91.78	Sask. 88.06	Nfld. 87.20
1975	B.C. 124.51	Alta. 110.12	N.S. 107.03	P.E.I. 100.03	Ont. 99.24	Man. 97.52	N.B. 93.31	Sask. 92.00	Nfld. 90.74	Que. 85.36
1976	B.C. 123.46	Alta. 109.04	N.S. 105.68	Man. 100.26	P.E.I. 98.61	Ont. 98.27	N.B. 92.26	Que. 91.39	Nfld. 90.67	Sask. 90.05
1977	B.C. 123.25	Alta. 111.14	N.S. 102.75	Man. 99.55	Ont. 98.68	Que. 97.93	P.E.I. 97.25	Sask. 92.35	N.B. 90.20	Nfld. 86.52
1978	B.C. 125.75	Alta. 112.06	N.S. 102.57	Man. 99.72	P.E.I. 99.09	Ont. 98.20	Sask. 93.21	Que. 93.00	N.B. 89.61	Nfld. 86.41
1979	B.C. 125.93	Alta. 112.24	N.S. 102.20	Man. 100.34	P.E.I. 97.64	Ont. 96.95	Sask. 93.83	N.B. 92.48	Que. 91.37	Nfld. 86.66
1980*	B.C. 122.44	Alta. 114.81	N.S. 100.54	Man. 97.81	P.E.I. 97.41	Ont. 95.00	Sask. 94.80	N.B. 88.68	Nfld. 88.49	

*Quebec figure not available.

TABLE 2

PERCENTAGE INCREASE IN EXPENDITURES FOR ONTARIO GOVERNMENT, MINISTRY OF HEALTH AND OHIP FEE-FOR-SERVICE

	1973-1974		1975-1976		Percentage Increase in 2 year period 1973-74 to 1975-76	1975-1976		Revised (1) 1980-1981		Percentage Increase in 5 year period 1975-76 to 1980-81	7 yrs. 73-74 to 80-81
	$M	% Govt. % MOH	$M	% Govt. % MOH		$M	% Govt. % MOH	$M	% Govt. % MOH		
BUDGETARY EXPENDITURE (2)											
Government	7,223		10,490		45·2	10,490		16,759		59·8	132
MOH	2,003	27.7	2,942	28.0	46·9	2,942	28.0	4,767	28.4	62·0	136
OHIP Fee-For-Serv (3)	486	24.3	629	21.4	29·4	629	21.4	1,122	23.5	78·4	130
BUDGETARY EXPENDITURE (2) + DISBURSEMENTS + CHARGES											
Government	7,905		11,319		43·2	11,319		17,171		51·7	117
MOH	2,036	25.8	2,974	26.3	46·1	2,974	26.3	4,804	28.0	61·5	136
OHIP Fee-For-Serv (3)	486	23.9	629	21.1	29·4	629	21.1	1,122	23.4	78·4	130
BUDGETARY EXPENDITURE (2) + DISBURSEMENT, + CHARGES − PUBLIC DEBT INTEREST											
Government	7,381		10,594		43·5	10,594		15,557		46·8	111
MOH	2,036	27.6	2,974	28.1	46·1	2,974	28.1	4,804	30.9	61·5	136
OHIP Fee-For-Serv (3)	486	23.9	629	21.1	29·4	629	21.1	1,122	23.4	78·4	130

(1) Expenditures increased $50 million to reflect shortfall in estimate

(2) Adjusted to reflect transfer of Mental Retardation Programs

(3) Includes Special Payment arrangements but excludes laboratory payments

SOURCE:

Ontario Budget; 1976 to 1980

Public Accounts: Volume I, Financial Statements

TABLE 3

OHIP EXPENDITURE DATA FOR FEE-FOR-SERVICE ALL PHYSICIANS EXCLUDING LABORATORY PAYMENTS BROKEN DOWN BY COMPONENT

INCREASE IN PAYMENTS ATTRIBUTABLE TO

May to April	Payments $000's	Increase %	Price Revision %	Utilization (% Increase)				
				Physician Supply				
				Meeting Pop Inc.	Over & Above Pop.	Total	Services Per Phys.	Total
1973-1974	488,600							
1974-1975	565,314.5	15.7	7.75	1.8	2.4	4.2	3.1	7.4
1975-1976	622,559.4	10.1	4.0	1.5	2.5	4.0	1.8	5.9
1976-1977	685,036.8	10.0	8.1	1.1	0.6	1.7	0.1	1.8
1977-1978	767,541.2	12.0	6.5	1.1	0.4	1.5	3.6	5.2
1978-1979	856,056.3	11.5	8.6	0.9	0.6	1.5	1.2	2.7
1979-1980	964,332.8	12.6	8.3	0.9	1.1	2.0	2.0	4.0
1980-1981(1) (Projected)	1,100,000.0	14.1	7.4	0.9	2.1	3.0	3.1	6.2
Percentage Increase from 1973-1974 to 1980-1981		125.1	63.0	8.5	10.0	19.3	15.8	38.1
$000 Increase from 1973-1974 to 1980-1981	611,400	611,400	307,800	41,500	52,800	94,300	209,300	303,600

ESTIMATED NET INCOME FROM OHIP AND WCB FEE-FOR-SERVICE PRACTICE UTILIZING AVERAGE OHIP PAYMENTS GROSSING ABOVE THE 30TH. PERCENTILE AND NHW (H.I.D.) OVERHEAD RATES FOR PHYSICIANS EARNING MORE THAN $20,000 NET

General Practice	1977	% Inc. 78 over 77	1978	% Inc. 79 over 78	1979	% Inc. 80 over 79	1980
Gross							
OHIP Payments	$64,600		$ 69,700		$ 77,800		$ 90,365
WCB Payments	1,000		1,200		1,400		1,626
Total	$65,600		$ 70,900		$ 79,200	Jan./Aug/80 Experience	$ 91,991
Expenses	$26,174		$ 28,246		$ 30,816		$ 33,928
*Net Income	$39,426	8.19%	$ 42,654	13.43%	$ 48,384	20.00%	$ 58,063
Specialists Gross							
OHIP Payments	$95,200		$102,400		$111,600	Jan./Aug./80 Experience	$125,729
WCB Payments	1,300		1,500		2,900		3,267
Total	$96,500		$103,900		$114,500		$128,996
Expenses	$32,578		$ 35,087		$ 38,280		$42,146
*Net Income	$63,922	7.77%	$ 68,813	10.76%	$ 76,220	13.94%	$ 86,850
All Physicians Gross							
OHIP Payments	$79,200		$ 85,400		$ 94,100	Jan./Aug./80 Experience	$107,453
WCB Payments	1,100		1,300		1,900		2,170
Total	$80,300		$ 86,700		$ 96,000		$109,623
Expenses	$29,382		$ 31,767		$ 34,658		$ 38,158
*Net Income	$50,918	7.89%	$ 54,933	11.67%	$ 61,342	16.50%	$ 71,465

*This net income does not include any earnings from such items as – Extra-billing, non-insured services, such as cosmetic surgery, insurance examinations, medical legal reports, completing certificates, driver license examinations, accupuncture, telephone advice, genetic counselling, services to non-residents, D.V.A. recipients and members of the Armed Forces.

TABLE 5

HEALTH INSURANCE DIVISION, HEALTH AND WELFARE CANADA
RANKING OF PROVINCES ON AVERAGE NET PROFESSIONAL EARNINGS (1)
OF ALL PHYSICIANS WITH NET PROFESSIONAL INCOME OF $20,000 AND OVER

YEAR	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	CANADA
1973	Que. $49,764	Ont. $46,244	N.B. $45,581	Nfld. $45,474	Alta. $45,334	N.S. $45,017	Sask. $44,211	Man. $43,226	B.C. $39,278	P.E.I. $38,419	$46,022
1974	Nfld. $51,551	Que. $50,425	N.S. $47,177	Ont. $46,235	Alta. $45,903	N.B. $45,055	Man. $44,235	Sask. $42,883	B.C. $42,320	P.E.I. $40,568	$46,765
1975	Nfld. $52,569	N.S. $52,264	Que. $51,592	Alta. $50,159	Ont. $48,869	N.B. $48,221	Sask. $47,426	B.C. $47,011	Man. $45,313	P.E.I. $41,580	$49,419
1976	Nfld. $55,542	N.S. $53,543	Alta. $52,207	B.C. $52,203	Que. $51,129	Ont. $50,326	N.B. $49,365	Sask. $48,145	Man. $47,608	P.E.I. $43,175	$50,902
1977	N.S. $57,064	Que. $54,644	B.C. $53,455	Alta. $53,270	Ont. $52,722	Nfld. $52,552	N.B. $51,048	Sask. $50,180	Man. $48,901	P.E.I. $46,665	$53,304
1978	N.S. $58,104	Que. $57,478	Ont. $55,558	B.C. $54,951	Alta. $54,743	N.B. $53,633	Nfld. $53,414	Man. $52,331	Sask. $51,865	P.E.I. $48,661	$55,810

(1) Net Professional Income from practice. Wages and salaries and non-professional income excluded. Income figures derived from all returns.

SOURCE: Health Insurance Division
Health Resources Directorate
Health and Welfare Canada

APPENDIX

MEMORANDUM OF AGREEMENT dated this 21st day of June, 1979

BETWEEN:

HER MAJESTY IN RIGHT OF ONTARIO
(hereinafter called "the Government")

-and-

ONTARIO MEDICAL ASSOCIATION
(hereinafter called "the OMA")

Definitions

"Act" means The Health Insurance Act, 1972;

"Regulations" means the Regulations made under the Act;

"Schedule" means the Schedule of Benefits in the Regulations with respect to amounts payable by OHIP for insured services rendered by physicians in Ontario;

"Global revision" means a percentage change in the total of the amounts payable in the Schedule;

"Detailed allocation" means changes in individual amounts and in nomenclature, definitions and preambles in the Schedule for the purpose of implementing a global revision;

"Parties" means the Government and the OMA.

Preamble

Whereas the OMA is the sole negotiator on behalf of the physicians of Ontario generally with respect to the Schedule;

And whereas the parties have agreed to conduct negotiations with respect to global revisions before any general amendment to the Schedule;

Application

1. The negotiations between the parties with respect to global revisions will be conducted in accordance with the provisions of this memorandum. Revision of the Schedule during the term of any memorandum of Agreement hereunder will be with the Consent of both parties.

The Committee

2. The parties will establish a committee comprised of three representatives appointed by the Government, three representatives appointed by the OMA, and a chairman appointed jointly by the parties.

3. The objective of the Committee is to negotiate a written Memorandum of Agreement on a global revision to the Schedule then in force, for recommendation to the parties.

4. The chairman will be appointed for a period equivalent to the negotiation of two successive global revisions, subject to reappointment by the parties.

5. The chairman shall not have a vote in the Committee.

6. The chairman's responsibility shall be
(a) to provide leadership and direction to the Committee;
(b) to co-ordinate data for the use of the Committee; and
(c) to help reconcile differences between the parties' representatives on the Committee.

Invoking Negotiations

7. Either party may invoke negotiations by giving written notice to the other party, at any time after six (6) months (or such other period of time as the parties may from time to time agree to) from the effective date of the prior Memorandum of Agreement, that it desires to negotiate with respect to a global revision.

Function of The Committee

8. Negotiations between parties with respect to global revision shall be carried on by the Committee.

9. Upon notice having been given under paragraph 7, the Committee shall commence negotiations at an early date thereafter and shall continue to negotiate in good faith with respect to a global revision.

10. If the Committee achieves majority agreement of its members with respect to a global revision it shall recommend the global revision to the parties.

11. If the Committee does not achieve majority agreement with respect to a global revision and either party is of the opinion that the negotiations are at an impasse, such party may request the chairman to act as a fact finder and in such event the chairman shall act as a fact finder.

Fact Finder

12. The chairman's responsibility as fact finder shall be to recommend in writing an appropriate global revision to the Committee.

13. The chairman's recommendations shall be reported to the Committee as expeditiously as possible but in any event within three (3) weeks of his having been requested to act as a fact finder.

14. The chairman shall not make public his recommendations to the Committee.

Further Function of the Committee

15. The chairman's recommendations shall not be binding on the Committee but shall be for the advice and guidance of the Committee, and upon receipt of the recommendations the Committee shall endeavour in good faith to reach a majority agreement with respect to a global revision.

16. If the Committee still does not reach a majority agreement with respect to a global revision and either party is of the opinion that the negotiations are at an impasse, such party may give written notice of its opinion to the other party and in such event the negotiations will be deemed to be at an end.

17. Notwithstanding paragraph 16, the Committee may resume the negotiations at any time by agreement between the parties.

18. Either party may make public the recommendations of the chairman after seven (7) days after its receipt by the Committee provided that the other party is given two (2) working days' advance notice.

Detailed Allocation

19. Where the Committee has recommended a global revision to the parties and the parties have agreed thereto, the OMA will determine the detailed allocation subject to the approval of the Lieutenant Governor in Council.

Compensation

20. Each party will compensate its own representatives on the Committee. The parties will jointly compensate the chairman. The Government will pay any costs incurred by the chairman in the course of his acting as a fact finder.

Periodic Review

21. The parties will jointly review the foregoing provisions for negotiation at least biennially.

General Responsibilities of the Parties

22. Nothing in this Memorandum derogates from the lawful responsibilities of either party.

IN WITNESS WHEREOF the parties have executed this Memorandum as of the date first above written.

HER MAJESTY IN RIGHT OF ONTARIO

Per: _____
Minister of Health

ONTARIO MEDICAL ASSOCIATION

Per: _____
President